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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

KENT E. KIMBERLY, M.D., an individual,

Plaintiff,

v.

SHARP REES-STEALY MEDICAL GROUP INC. GROUP LONG TERM DISABILITY INSURANCE PLAN

Defendants.

CASE NO.: **08 cv 0157 JLS (POR)**

PLAINTIFF'S REQUEST FOR JUDICIAL NOTICE OF THE POSITION OF THE SECRETARY OF LABOR IN OPPOSITION TO DEFENDANT SHARP REES-STEALY MEDICAL GROUP INC. GROUP LONG TERM DISABILITY INSURANCE PLAN'S MOTION TO STRIKE PURSUANT TO FED.R.CIV.P. 12(f) OR, IN THE ALTERNATIVE, MOTION TO DISMISS PURSUANT TO FED.R.CIV.P. 12(b)(6)

Date: July 17, 2008
Time: 1:30 PM
CTRM: 6 (Third Floor)
JUDGE: Honorable Janis L. Sammartino

Plaintiff, **KENT E. KIMBERLY, M.D.** ("Plaintiff"), by and through his attorneys, requests this Court take judicial notice pursuant to Federal Rule of Evidence 201, of the following facts or matters:

1. the position of the Secretary of Labor answering the question of whether an administrator of a disability plan is required by ERISA to disclose any new evidence and materials developed by the administrator after the appeal but before a final decision —answering that question in the affirmative.

The Secretary's position statement is contained in the brief of the Secretary of Labor as Amicus Curiae, filed in the United States District Court for the Southern District of California, November 27, 2001, in Russo v. Hartford Life & Accident Ins. Co., Case No. 00 cv 0938 LSP (CGA), with which this Court agreed in Russo v. Hartford Life & Accident Ins. Co, 2002 U.S. Dist. Lexis 26566 (S.D. CA 2/5/2002).

While Hartford already knows of the Secretary's position —since it was stated in a case in which Hartford was the named defendant, specifically addressed Hartford's tactics of nondisclosure of all pertinent information to the claimant including after an appeal, and as a result, Hartford was found to have breached its fiduciary duty to the plaintiff— this Request for Judicial Notice of the Secretary's position as amici is based on Auer v Robbins, 519 US 452, 137 L Ed 2d 79, 117 S. Ct 905 (1997). The court in Auer held that an administrative agency's interpretation of its own regulation is entitled to deference and/or controlling weight unless it is plainly erroneous or inconsistent with the Regulation.[1] Accord, First Am. Discount Corp. v. CFTC, 222 F.3d 1008 (D.C. 2000);[2] Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). Since 1984, the Secretary's regulations promulgated through this process are entitled to "Chevron deference." See also, Nat'l Cable &Telecommunications Ass'n v. Brand X Internet Services, 125 S.Ct. 2688 (June 27, 2005); Black & Decker Disability Plan v. Nord, 538 U.S. 822, 8331-32, 123 S. Ct. 1965, 1970, 155 L.Ed. 2d 1034 (2003) ("If the Secretary found it meet to adopt a [certain] rule by regulation, courts would examine that determination with appropriate deference." (Citing Chevron); Yates. . . Profit Sharing Plan v. Hendon, 541 U.S. 1, 24-25, 124 S. Ct. 1330, 158 L. Ed. 2d 40 (2004). "Unless Congress, in enacting ERISA, demonstrated clearly its intent with regard to the questions before us, we must defer to the Secretary's official interpretations of ERISA if they are reasonable." (also citing Herman v NationsBank Trust Co., 126 F.3d 1354, 1363 (11th Cir 1997); and Anweiler v American Electric Power Service Corp.,

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[1] citing Robertson v. Methow Valley Citizens Council, 490 U.S. 332, 359, 104 L. Ed.2d 351, 109 S. Ct. 1835 (1989)

[2]The Secretary's authority to enact the regulations was delegated by Congress pursuant to ERISA §§ 503 and 505. Section 505 authorizes the Secretary to "*proscribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter*." 29 U.S.C. § 1135. Section 503 requires conformance with the claims regulations. 29 C.F.R. 2560.503-1, subsections "a" - "o". ("In accordance with Regulations of the Secretary. . . ." 29 USC § 1133.") Teen Help, Inc. v. Operating Eng'rs Health & Welfare Trust Fund, 1999 U.S. Dist. LEXIS 21989 (N.D. CA 8/24/99) (The Secretary of the [DOL] is charged with enforcing ERISA and its fiduciary duties, and she has the authority to render authoritative interpretations of the Act" citing 29 U.S.C. § 1132(a)(2).

3 F.3d 986, 993 (7th Cir 1992) (deferring to Secretary of Labor's interpretation of ERISA as contained in *amicus curiae* brief filed with the court).[3] It is of no matter that the Secretary's interpretation comes in the form of an *amicus* brief; that will not lessen the deference accorded it by the courts. Herman, supra; Hells Canyon Alliance v. United States Forest Serv., 227 F.3d 1170 (9th Cir. 2000) [9/24/2000] [Agency's interpretation set forth in amicus brief was entitled to deference, where "there is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question"]; Accord Christensen, supra, 529 U.S. 576. (citing Auer, Robertson and Christensen). United States v. Occidental Chem. Corp., 200 F.3d 143 (3d Cir. 1999) ("The Supreme Court case law teaches that we must defer to agency interpretations that are supported by "regulations, rulings, or administrative practice.")

The above explanation by the SOL in terms of her interpretation of her own regulations which govern ERISA —including her position in advancement of the underlying "employee protection" purpose of ERISA[4] —that the claim administrator must provide the claimant with any new information it develops after the claimant's appeal for comment prior to any final adverse review decision, and that the failure to do so constitutes a breach of fiduciary duty. Such interpretation, which takes precedent over any interpretation made by any of the courts in the various circuits that may be more limited or to the contrary, may be judicially noticed by this Court.

Respectfully submitted,

MILLER, MONSON, PESHEL, POLACEK & HOSHAW

Dated: **July 3, 2008**

By: /s Susan L. Horner
Susan L. Horner
Attorneys for Plaintiff,
Kent E. Kimberly, M.D.

[3]Pursuant to Auer, deference to the Secretary's interpretation about its regulations is also warranted when the language of its regulation is "ambiguous." Christensen v. Harris County, 529 U.S. 576; 120 S. Ct. 1655; 2000 U.S. LEXIS 3003; 146 L. Ed. 2d 621; 68 U.S.L.W. 4343 (May 1, 2000) citing Bowles, 325 U.S. 410 (1945).

[4] The central purpose of ERISA is employee protection. Schikore v. BankAmerica Supplemental SI (MEJ) Retirement Plan, 269 F.3d 956, 962-63 (9th Cir. 2001), citing 29 U.S.C.S. § 1001(b).

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

NOTICE OF DOCUMENT DISCREPANCIES

01 CV 0938 JLS (POR)
This space for Clerk's Office File Stamp

TO: ☐ U. S. DISTRICT JUDGE / ☐ U. S. MAGISTRATE JUDGE Papas
FROM: A. Victoria, Deputy Clerk RECEIVED DATE: 11/21/01
CASE NO.: 00cv938 DOCUMENT FILED BY: Dept of Labor
CASE TITLE: Russo vs Hartford Life
DOCUMENT ENTITLED: motion

Upon the submission of the attached document(s), the following discrepancies are noted:

✓	Local Rule	Discrepancy
☐	5.1.j.4	Missing time and date on motion and/or supporting documentation
☐	5.3.c	Document illegible or submitted on thermal facsimile paper
☒	7.1.e or 47.1.b.1	Date noticed for hearing not in compliance with rules/Document(s) are not timely
☐	7.1.f or 47.1.b.3	Lacking memorandum of points and authorities in support as a separate document
☐	7.1.h or 47.1.e	Briefs or memoranda exceed length restrictions
☐	7.1.h	Missing table of contents
☐	15.1	Amended pleading not complete in itself /Supplemental filings require court order
☐	30.1	Depositions not accepted absent a court order
☐		Default Judgment in sum certain includes calculated interest
☐		OTHER:

Date forwarded: 11/21/01

ORDER OF THE JUDGE / MAGISTRATE JUDGE

IT IS HEREBY ORDERED:

☑ The document is to be filed nunc pro tunc to date received.

☐ The document is NOT to be filed, but instead REJECTED and it is ORDERED that the Clerk serve a copy of this order on all parties.

Rejected document to be returned to pro se or inmate? ☐ Yes. Court Copy retained by chambers ☐

Counsel is advised that any further failure to comply with the Local Rules may lead to penalties pursuant to Local Rule 83.1

Dated: 11/28/01 (Thanks)
cc: All Parties

CHAMBERS OF: LSP
By: KMB

K:\COMMON\FORMS\CIVCRM35.WPD
Form # Civ/Crim 35 (4/98) – (Document Discrepancy / Court Order)

48

EXH. A- 1 to REQ.JUD.NOTICE

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

RICHARD S. RUSSO,

Plaintiff,

v.

HARTFORD LIFE AND ACCIDENT INS. CO. et al,

Defendants.

CASE NO: 00 CV 00938 LSP(CGA)

DATE: November 27, 2001
TIME: 1:30 PM
CTRM: G

U.S. Magistrate Judge,
Hon. Leo S. Papas

SECRETARY OF LABOR'S BRIEF AS AMICUS CURIAE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Case--continued:

Statutes:

Other Authorities:

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UNITED STATES DISTRICT COURT

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SECRETARY'S BRIEF AS AMICUS CURIAE

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U.S. Magistrate Judge,
Hon. Leo S. Papas

STATEMENT OF INTEREST

Pursuant to Section 503 of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1133, the Secretary of Labor issued a regulation establishing, among other things, procedures for a "full and fair" review of ERISA benefit claims. 29 C.F.R. § 2560.503-1 (1977). The regulation requires plans to disclose, upon request, "pertinent documents" during the administrative review of benefit claims. "Pertinent documents" include all documents used by the plan in making a final determination of

benefit eligibility. The Secretary has an interest in assuring that the courts interpret this regulation consistent with the purposes of the statute, which is to provide participants and beneficiaries with a meaningful review of benefit claims.[1]

STATEMENT OF ISSUES

1. Whether new evidence gathered after a plan's initial claim denial and used to deny the claim upon review is a "pertinent document" that must be disclosed, pursuant to ERISA § 503 and the Secretary's claims regulation, to the claimant upon his written request.

2. Whether the court should exercise its discretion to accept evidence from the claimant which was not part of the administrative record when the plan refused to disclose to the claimant, upon his written request, evidence that it relied upon in denying his benefit claim and an opportunity to refute such evidence.

STATEMENT OF FACTS

In 1982, Richard Russo began working for National Sanitary Supply Company ("National Sanitary") as an outside sales representative.[2] In January 1991, he suffered an acute heart attack. Two months later, he was again hospitalized with persistent symptoms and multivessel bypass grafting. He

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[1] The brief addresses the interpretation of the 1977 claims regulation. The Secretary has issued a new claims regulation; however, it is undisputed that the 1977 regulation is applicable to this claim which arose in 1991.

[2] Unless otherwise noted, the facts are taken from the July 12, 2001 Slip Opinion.

experienced post operative partial atelectasis (partially collasped lung) and at least six months of recurrent post-operative pulmonary and cardiac complications (post-pericardiotomy syndrome with pleuro-pericarditis) with associated symptoms. By September 1991, he was again hospitalized with unstable angina because a major graft had reoccluded.

Since 1991, Russo has suffered recurrent angina or anginal equivalent, progressive coronary disease, with ischemic left ventricular dysfunction and Chronic Obstructive Pulmonary Disease ("COPD"). Russo's disease-related symptoms and limitations are initiated and/or exacerbated by, among other things, physical exertion and/or stress. The Social Security Administration determined Russo to be totally disabled as of January 14, 1991.

National Sanitary bought long term disability insurance ("the plan") from Manufacturer's Life Insurance Co. The plan provides five years of coverage if an employee is unable to perform his own-occupation, and coverage thereafter if he is unable to perform any occupation. The plan does not grant the administrator discretion to determine claims. Russo applied for and received disability benefits on May 31, 1991. In October 1994, Hartford assumed administration of the policy.

Russo's former spouse, Mrs. Debra Thomas Russo, represented to Hartford in 1997, at the time of their divorce settlement negotiations, that Russo had not been disabled since late 1991, and that he was claiming benefits fraudulently. Hartford interviewed Mrs. Russo on March 13, 1998, and terminated Russo's

benefits by letter dated the same day, made effective March 1, 1998. The March 13, 1998 letter did not explain the basis for Hartford's decision, nor did it reveal the allegations made by Mrs. Russo. Compl. Ex. B.

Through counsel, Russo requested a complete copy of Hartford's administrative file and an explanation of the decision. Hartford did not provide either, but paid Russo's benefits by month's end. Id.; Compl. Ex. H. On November 18, 1998, Hartford issued a second denial letter. The letter cited evidence provided by Mrs. Russo, her parents, and friends. It also cited the opinion of a physician who had not examined Russo, but had reviewed medical and investigation records provided by Hartford, and concluded that Russo was not disabled. Although Hartford did not assume administration of Russo's policy until October 1994, it demanded that Russo repay Hartford approximately $100,000 for the benefits he had received since June 4, 1991.

Russo again asked for a copy of Hartford's claim file and all evidence relating to his claim. On or about December 22, 1998, Hartford gave Russo one box of documents.

On May 3, 1999, Russo appealed Hartford's denial. Russo submitted extensive evidence allegedly supporting his appeal, including witness statements, medical records, and evidence from his treating physicians showing his continued disability. Slip Op. at 3 and 9; Mot. in Liminie at 4. Russo alleges that the evidence accompanying his appeal rebutted the evidence Hartford had disclosed on December 22, 1998. Id.

Upon receipt of the appeal, Hartford began an additional

investigation of the "allegations and points raised in the appeal." Slip Op.at 3; Defs. Brief at H1296. On July 9, 1999, Hartford sent Russo's file to its appeals division. Mot. in Limine p. 3. By letter dated September 1, 1999, Hartford asked Russo to agree to an extension of time within which it could complete its investigation. On September 6, 1999, Russo asked Hartford in writing to allow him to review the additional evidence it was gathering. Instead of providing him with this evidence, Hartford issued a third and "final" denial letter on September 24, 1999.

PROCEDURAL HISTORY

Russo filed suit on May 8, 2000. Among other things, Russo alleges that Hartford relied extensively upon the new evidence that it developed during the appeal, but did not allow him to review or address. Slip Op. at 9; Mot. in Liminie at 4.[3] Hartford filed a counterclaim, seeking reimbursement from Russo in the amount of $98,871.24 plus interest and costs.

During litigation, Hartford produced six boxes of documents it characterized as the "administrative record." Slip Op. at 5 n. 7; Mot. in Limine at 4-5. These boxes contained evidence Hartford had not previously allowed Russo to review. Id. The evidence included interviews of 16 new witnesses whose names and/or statements Hartford had not disclosed to Russo; follow-up

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[3] Russo's complaint also alleges that the September 24, 1999, denial letter did not address the evidence he had submitted on May 3, 1999 to rebut the evidence Hartford relied upon in its November 18, 1998 denial letter; did not address the medical or vocational evidence Russo had submitted; and did not address his stress-related cardiac limitations. Slip Op. at 4; Compl. Ex. R.

interview notes from the six witnesses whose initial interview notes it had disclosed on December 22, 1998; and a surveillance tape Hartford recorded of Russo over a two-day period after his appeal. Slip Op. at 5; Mot. in Limine at 4-5. By motion, Russo asked the court to exclude any evidence Hartford used to deny the claim but did not allow him to review or address, arguing that Hartford's conduct was contrary to the Department's claims regulation, § 2560.503-1(g)(1), and a breach of fiduciary duty warranting exclusion of the undisclosed evidence. Slip Op. at 5, 9-10; Mot. in Limine at 5, 10-11. Russo sought an order excluding the September 24, 1999 final denial letter; the interviews of witnesses whose names and/or statements Hartford had not disclosed; the follow-up interview notes from the witnesses whose initial interview notes it had disclosed on December 22, 1998; and the surveillance tape. Slip Op. at 5; Mot. in Limine at 4-5.

By motion, Hartford asked the court to rule that all evidence it used to decide the claim constituted the administrative record. Hartford argued that an administrator has no duty to disclose documents generated during the appeal process if the denial letter adequately describes the basis for the decision. See Brief On Determination of Administrative Record ("Administrative Record Brief") at 7-9.

On July 12, 2001, this court denied Russo's motion. See "Order Denying Plaintiff's Motion In Limine And Denying Plaintiff's Request For Judicial Notice." The court ruled that the opportunity to review "pertinent documents" was critical to a

full and fair review of a claim denial, but that Hartford was under no duty to provide Russo "with latter evidence upon which they relied in conducting the final review." Slip Op. at 10, citing Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 238 (4th Cir. 1997). The court further ruled that it was required to review all of the evidence that Hartford had considered in reaching its final decision and would consider further briefing as to whether "exceptional circumstances exist that may warrant an exercise of the Court's discretion to allow additional evidence." Id. at 11 and 15. On September 21, 2001, Russo moved for reconsideration of the Court's ruling, and the Secretary files this brief in support of that motion.

ARGUMENT

A. Statutory and Regulatory Background

The Congressional purpose of ERISA is to promote the interests of employees and beneficiaries and protect contractually defined benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-14 (1989). To accomplish these goals, ERISA § 503[4] requires plans to give claimants the specific

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[4] ERISA § 503 states:

In accordance with regulations of the Secretary, every employee benefit plan shall-

> 1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> 2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the

reasons for denying a claim and an opportunity for a "full and fair review" of the denial by the appropriate named fiduciary. 29 U.S.C. § 1133(2).

Pursuant to ERISA § 503, the Secretary promulgated a claims regulation that specifies the minimum requirements for plan procedures for the consideration and review of benefit claims. See § 2560.503-1. The 1977 claims regulation requires that every plan shall establish and maintain reasonable claims procedures. See § 2560.503-1(b); 42 Fed. Reg. 27426 (May 27, 1977). At a minimum, a reasonable claims procedure must be described in the summary plan description, and must not be administered in a manner that unduly inhibits or hampers the filing or processing of claims. It must establish a procedure for informing participants in a timely fashion of the time periods for making claims and for making decisions on claims.

The initial notice must contain: 1) the specific reason or reasons for the denial; 2) specific reference to pertinent plan provisions supporting the denial; 3) a description of any additional material or information required to perfect the claim and an explanation of why it is necessary; and 4) appropriate information as to the steps to be taken to submit the claim for review. See § 2560.503-1(f). Pursuant to a "written request," plan procedures must allow claimants to "review pertinent documents" and "submit issues and comments in writing." See § 2560.503-1(g)(1).

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claim.

ERISA § 502(a)(1)(B) authorizes a claimant to file a civil action to obtain wrongfully denied benefits. 29 U.S.C. § 1132(a)(1)(B). Courts, however, have interpreted ERISA to require that claimants first exhaust available administrative remedies.

B. The Regulation Gives Claimants The Right To Review Pertinent Documents At Any Time During the Review Procedure.

The Secretary's claims regulation is designed to assure the fairness of a plan's claim review procedure. As discussed below, the language of the claims regulation does not limit a plan's duty to disclose "pertinent documents" upon request to evidence received or developed before the initial benefit denial, but instead includes all documents relied upon by the plan in making the final benefit determination. Moreover, this interpretation is consistent with court decisions construing the elements of a "full and fair review" under ERISA and with the purposes of requiring participants to exhaust internal appeal procedures before filing an action in court.

1. The regulation gives claimants, upon written request, the right to review evidence used to decide the claim at a time when they have a reasonable opportunity to address it.

The Secretary's claims regulation, by its terms, provides that a claimant may "review pertinent documents" during the appeal of the initial benefit denial. The regulation does not limit review of "pertinent documents" to evidence received or developed by the plan prior to the initial claim denial. Instead, the right to "review pertinent documents" under

paragraph (g), entitled "Review Procedure," by its terms, applies to all documents gathered by the plan and relied upon to affirm the initial denial. See § 2560.503-1(g) ("Review Procedure").

The right to review "pertinent documents" turns upon whether the claimant made a written request (§ 2560.503-1(g)(1)(i)) and whether the documents are "pertinent" (§ 2560.503-1(g)(1)(ii)). As the preamble to the 1977 claims regulation makes clear, "pertinent documents" include all documents "relating to the denial." 42 Fed. Reg. 27426 ("[u]nder paragraph (g), plan procedures for review of claim denials must include the right of a claimant ... to review pertinent documents relating to the denial and submit issues and comments in writing"). See also, Palmer v. University Med. Group, 994 F. Supp. 1221, 1224 (D. Or. 1998) ("pertinent documents" include "all documents which the claims administrator considered or relied upon when it decided to deny benefits").[5]

The purpose of the regulation is to give claimants the right to review evidence used to deny a claim at a time when they have a reasonable opportunity to address it -- without regard to when the plan obtained it. Vega v. National Life Ins. Servs., Inc., 188 F.3d 287, 299-300 (5th Cir. 1999) (en banc). Under § 2560.503-1(g)(1)(iii), claimants have the right to "submit issues and comments in writing" during the appeal. "The opportunity to review the pertinent documents is critical to a full and fair

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[5] See Hensley v. Northwest Permanente P.C. Retirement Plan & Trust, 258 F.3d 986 (9th Cir. 2001) (criticizing Palmer on other grounds).

review, for by that mechanism the claimant has access to the evidence upon which the decision-maker relied in denying the claim and thus the opportunity to challenge its accuracy and reliability." Ellis, 126 F.3d at 237. The right to submit issues and comments in writing would be meaningless if the claimant did not have access to those documents which formed the basis for the ultimate denial of the claim. The regulation cannot be fairly interpreted to authorize plans to gather new evidence after the initial denial, use that evidence to affirm the denial on appeal, but never give the claimant the opportunity to challenge the evidence upon which the plan ultimately relies. Such an interpretation would force ERISA plan participants to file suit without knowing the basis for the plan's decision. This result is exactly what the regulation was intended to avoid, and it wastes the often limited resources of disabled ERISA plan participants, plans, and the courts by fostering litigation rather than administrative claim resolution.

2. The Secretary's interpretation of the regulation is consistent with court decisions holding that a full and fair review under ERISA § 503 entitles claimants to review all evidence used to decide the claim.

The Secretary's construction of the claims regulation is consistent with decisions construing the elements of a "full and fair review" under ERISA. As the Third Circuit held, to afford a "full and fair review" on appeal, the administrator must "inform the participant of what evidence he relied upon and provide him with an opportunity to examine that evidence and to submit written comments or rebuttal documentary evidence." Grossmuller

v. International Union, United Auto. Aerospace & Agric. Implement Workers of Am., UAW, 715 F.2d 853, 858-59 (3rd Cir. 1983). Construing § 2560.503-1(g)(1)(i)-(iii). Accord, Wilczynski v. Lumbermens Mut. Cas. Co., 93 F.3d 397, 402 n.3 (7th Cir. 1996) ("the requirement that a claimant be permitted to 'review pertinent documents' ensures that a full and fair review is conducted by the plan administrator, enables the claimant to prepare adequately for further administrative review or eventual recourse to the federal courts, and makes it possible for the courts to perform the task ... of reviewing that denial") (emphasis added).[6] "[T]he persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." Grossmuller, 715 F.2d at 858 n.5 (surveying interpretations of "full and fair" arising under varying statutes).

In Grossmuller, the administrator disqualified a retired pensioner from receiving benefits relying upon a tip. 715 F.2d at 858-59. The administrator then hired a detective who appeared

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[6] In Wilczynski, after two unsuccessful levels of internal review, the claimant retained counsel to assist her with the third and final administrative review. 93 F.3d at 399. When counsel requested the "administrative file," the administrator deemed the request an "all-or-nothing" demand for more than the "pertinent documents" available under § 2560.503-1(g)(1)(ii) and chose to provide nothing. Id. at 403. The court noted that the administrator's apparent "gamesmanship" was "inconsistent with the mandate of 29 U.S.C. § 1133" and undermined the purpose of requiring administrative exhaustion. Id.

before it and showed a video, allegedly, of Grossmuller tending bar at a country club. Based upon an interview with the club's owner, the detective reported that Grossmuller was working there. Without disclosing the evidence it considered, the administrator terminated Grossmuller's benefits. On appeal, Grossmuller asked to appear and testify before the administrator. The administrator denied the appeal without allowing him to appear, to examine the adverse evidence, or to submit written comments or rebuttal evidence. Id. at 856. The court held that the district court had "properly concluded that the plan's claims procedure failed to comply with ERISA's requirements for 'full and fair review'" of the claim denial. Id. at 859.

Even without an affirmative failure to disclose evidence upon request, courts have found that the administrator denied a full and fair review when procedural irregularities in the claim review procedure interfered with a claimant's opportunity to present evidence. Friedrich v. Intel Corp., 181 F. 3d 1105, 1111 (9th Cir. 1999) (upholding admission of additional evidence from the claimant while refusing additional evidence from Intel because its flawed initial claim process and appeal procedure had prevented the claimant from submitting the evidence he needed to support his claim). Cf. Dishman v. UNUM Life Ins. Co. of Am., 2001 WL 12068, at *8 (9th Cir. Oct. 17, 2001) (upholding admission of evidence from outside of the insurer's internal claim file after it denied the claimant an administrative review of a benefit "suspension").

3. The Secretary's interpretation of the claims regulation is consistent with the requirement that participants exhaust administrative remedies before filing an action in court.

This construction of the regulation is also consistent with the rationale for requiring the exhaustion of administrative remedies. As the Ninth Circuit explained in Amato v. Bernard, 618 F.2d 559, 566-68 (9th Cir. 1980), the exhaustion requirement assists the courts in resolving litigated controversies by presenting fully considered decisions. Id. at 567-68.[7] Thus, the appeal and review procedure is an important, possibly curative, step in the claims process. This purpose is frustrated if the claimant cannot learn the full evidentiary basis for the decision until he files a lawsuit, and the court cannot learn until trial whether the claimant has explanatory or rebuttal evidence that addresses the evidence used to deny the claim.

In Palmer, 994 F. Supp. at 1240, the plaintiff learned during litigation that the insurer had withheld numerous documents during the claim review process. The court noted that the deferential review standard[8] gives special importance to the procedures mandated by the claims regulation.

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[7] See also, e.g., Powell v. A.T. & T. Communications, Inc., 938 F.2d 823, 827 (7th Cir. 1991) (Congress's apparent intent in mandating the internal claims procedures found in ERISA was to reduce frivolous lawsuits; promote consistent treatment of claims; provide a nonadversarial dispute resolution process; and decrease the cost and time of claims settlement); Ellis, 126 F.3d at 238 (same).

[8] Although this case will be reviewed de novo based upon the plan terms, the regulation applies to cases reviewed under both the de novo and the arbitrary and capricious standard of review.

> The Plan's internal review process may be the claimant's last genuine opportunity to influence the final decision, to supplement the record in preparation for judicial review, or to correct any errors in the existing record. Meaningful participation in this internal review process therefore requires that the claimant have an opportunity to review the relevant documents in the claim file so the claimant may submit any additional documents, correct any errors in the record, point to any favorable evidence that would tend to support the claim, fully understand the reasons for the decision that is being appealed, and to otherwise prepare an informed response to that decision.

Id. The court held that when an administrator fails to disclose the basis of the decision and that failure interferes with the claimant's ability to present evidence supporting his claim, a court should not defer to the administrator's decision or rely upon its fact-finding and, therefore, reversed the decision as arbitrary and capricious.

An interpretation of the regulation that allows plans to withhold evidence used to justify a claim denial undermines the rationale for limiting the court's review of evidence to what was before the plan, and forces the courts to admit and evaluate evidence that should have been considered and weighed by the plan. Dishman, 2001 WL 120658 at *8 ("[i]f UNUM did not want Dishman to be able to [present evidence at trial,] then UNUM should have followed the proper procedures and allowed [him] to present that information to it in the first instance ... ."); Friedrich, 181 F. 3d at 1111; Vega, 188 F.3d at 299 n.13 ("the claimant only has an opportunity to make his record before he files suit in federal court, it would be unfair to allow the administrator greater opportunity at making a record than the claimant enjoys"); Palmer, 994 F. Supp. at 1240.

The claims regulation must be construed in a manner that protects claimants, plans, and the courts. For claimants, knowledge of the evidentiary basis for the decision ensures that they have a reasonable opportunity to understand the evidence on which the decision will be based and to supplement that evidence if appropriate without resorting to litigation. As the Fourth Circuit said in construing § 2560.503-1(g), "[t]hese procedural guidelines are at the foundation of ERISA." Weaver v. Phoenix Home Life Mut. Ins. Co., 990 F.2d 154, 157 (4th Cir. 1993). Congress intended that claimants have the opportunity to resolve claims without having to resort to the expense and delay of litigation. Id. citing Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1007 n.4 (4th Cir. 1985). For plans and the courts, the claimant's opportunity to review and address evidence used to deny the claim ensures that the final decision is based upon a complete and accurate record -- the underlying premise that supports both the deferential standard of review and the exhaustion of administrative remedies requirement. Vega, 188 F.3d at 300 (vigilant enforcement of "procedural rules encourage the parties to resolve their dispute at the administrator's level"). These important doctrines foster judicial economy.

4. The decision in Ellis does not support Hartford's position.

Ellis does not support an interpretation of the claims regulation that denies claimants the right to review all evidence gathered during an appeal. Rather, Ellis is a fact-driven decision that holds, based upon the facts of the case, that Ellis

"was not subject to an arbitrary or unprincipled decisionmaking process." 126 F.3d at 238-39. The court in Ellis examined whether MetLife denied a full and fair review by failing to give Ellis two reports that contained essentially the same evidence she already had. Id. ("MetLife provided a copy of the ... second report to Ellis's health care providers. This second report was even more detailed than the first, and it made clear that the available data on her functional limitations did not preclude her from engaging in the physical tasks of her profession.") On these facts, the court found that Ellis had not "been prejudiced by the deficiencies" in MetLife's claim review process. Id.

The Ellis court cautioned, however, that it was upholding MetLife's decision only because MetLife gave Ellis the basis for its denial, and she had an opportunity to address that evidence. The court noted that "[t]he opportunity to review the pertinent documents is critical to a full and fair review, for by that mechanism the claimant has access to the evidence upon which the decision-maker relied in denying the claim and thus the opportunity to challenge its accuracy and reliability." The court emphasized that "MetLife is saved in this instance only because the substance of the review that [it] did provide to Ellis was full and fair, even though it did not technically comply with all of ERISA's procedural requirements." Id. at 237. That is not the situation here, where Hartford has not disclosed evidence that it ultimately relied upon in denying Russo's claim on appeal.

C. This Court Has Discretion To Admit Evidence Not Contained In Hartford's Claim File.

The Ninth Circuit reviews the decision to admit or exclude evidence for an abuse of discretion. Friedrich, 181 F.3d at 1111. When a benefit denial is reviewed under a de novo standard, a district court may admit additional evidence if "'circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision.'" Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 944 (9th Cir. 1995), quoting Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc).

Whether to admit evidence must be decided in view of the underlying judicial purpose for limiting evidence to the administrative record. As the Fifth Circuit has observed, in restricting evidence in the administrator's record, "we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants." Vega, 188 F.3d at 300. Consistently, in certain circumstances, the Ninth Circuit has ruled that the administrative record cannot serve as the exclusive basis for the review of a benefit denial. For example, in Mongeluzo, it upheld the admission of evidence not included in the administrative record when benefits were denied under a misconception of the law. 46 F.3d at 944. In Dishman, it refused to limit evidence to the insurer's internal claim file

when the insurer failed to provide any administrative review procedure of a "suspension" of benefits. 2001 WL 1230658 at *8. In Friedrich, the Ninth Circuit upheld the admission of additional evidence from the claimant while denying Intel an opportunity to submit additional evidence because the review procedure prevented the claimant from submitting the medical evidence required to rebut the opinions of the plan's medical consultants. 181 F.3d at 1111.

When Hartford gathered new evidence of sufficient materiality that it is used to justify the claim denial, it had a duty to allow Russo to review that evidence upon his request and submit additional comments or evidence. Because it did not give Russo that opportunity, the record in this case is incomplete and insufficient to determine whether Hartford's decision was correct. Such a failure of procedural due process justifies the consideration of evidence from outside the administrative record. See Friedrich, 181 F.3d at 1110-1111. See also, Killian v. Healthsource Provident Administrators, Inc., 152 F.3d 514 (6th Cir. 1998). In Killian the administrator refused to accept new information that the insured offered to support her claim. Id. at 521-22. The plan did not require exclusion of the new information, and the administrator in fact considered new information favorable to the denial. Id. at 522. The Sixth Circuit found an abuse of discretion for the administrator to have treated the record as closed and concluded its "behavior makes no sense in the absence of an improper financial motive, and we therefore infer that Healthsource's actions were shaped by

its conflict of interest." Id. at 522. As the court stated, "it is not open to a plan administrator to curtail consideration of the information propounded by the plan beneficiary, while continuing to accumulate information that bolsters a denial decision already made." Id. at 521 (the court remanded the matter to the administrator to consider relevant material it had originally excluded).

CONCLUSION

Hartford's claim review procedure denied Russo a "full and fair" review of its decision. Thus, as the foregoing cases illustrate, the court should admit evidence from outside Hartford's claim file to facilitate its de novo review.

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